IHCP Provider CLIA Certificate Maintenance Form

in.gov/medicaid/providers

Enrolled providers use this form to submit changes to Clinical Laboratory Improvement Amendment (CLIA) Certificate information.

The Centers for Medicare & Medicaid Services (CMS) assigns a CLIA number to each specific service location, unless a provider meets the criteria for CMS exemption. Generally, after the Indiana Health Coverage Programs (IHCP) processes CLIA certificate information for a provider, the provider is not required to submit a maintenance form to extend the effective period for the certificate. CMS updates the expiration dates on CLIA certificates, and the IHCP maintains this information in *Core*MMIS. You need to submit a maintenance form **only** in the following circumstances:

- If the certificate type changes
- If the address changes as a result of relocation of a service location. In this case, you must also submit an *IHCP Name and Address Maintenance Form* to report the new address
- If you wish to provide notification that laboratory services are no longer rendered at a service location

Multisite Laboratories

A CLIA certificate is required for each location where laboratory testing is performed unless the lab qualifies for one of the following CMS exemptions:

- Laboratories that are not at a fixed location (that is, laboratories that move from testing site to testing site, such as mobile units providing laboratory testing, health-screening fairs, or other temporary testing locations) may be covered under the certificate of the designated primary site or home base, using its address; include all applicable CLIA certificates with the enrollment packet.
- Not-for-profit or federal, state, or local government laboratories that engage in limited public health testing (not more than a combination of 15 moderately complex or waived tests per certificate) might have multiple CLIA certificates that apply to the service location; include all applicable CLIA certificates with the enrollment packet.
- Laboratories within a hospital that are located at contiguous buildings on the same campus and under common direction might have a single or multiple CLIA certificates for the laboratory sites within the same physical location or street address. Include all applicable CLIA certificates with the enrollment packet.

Next Steps

1. After completing this form, perform a quality check using the following checklist. The quality check helps ensure that your maintenance request can be processed and that it does not have to be returned for corrections.

For Provider Use Only	Quality Check
	Make sure you clearly identify the billing provider service location and appropriate CLIA information in items 1 – 12.
	Complete the contact information in items 13 – 15.
	Sign the form; an original signature is required.
	Enclose a copy of the CLIA certificates for the service location to which the maintenance request applies.

2. Make a copy of the maintenance form and other documentation for your records.
3. If you need additional maintenance forms, return to in.gov/medicaid/providers and select another form.
4. Place all forms and required documentation in an envelope.
5. Mail the maintenance forms and other required documentation to the following address:

   IHCP Provider Enrollment
   PO Box 50443
   Indianapolis, IN 46250-0418

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Provider and Service Location Identification Where CLIA Certificate Applies		
1. Legacy Provider Identifier (LPI) and service location alpha suffix	2. National Provider Identifier (NPI)	3. Taxonomy code
4. Doing business as (DBA) name		
5. DBA street address		
6. City	7. State	8. ZIP + 4 **(Nine digits required)**

IHCP CLIA Certificate Maintenance Information
(List additional CLIA certificates on a separate sheet of paper.)

Document your CLIA certificate information in this section. CLIA numbers are assigned to a specific service location unless CMS exemption status is met.

9. CLIA number	10. Certification type	11. Effective date	12. Expiration date

Note: A copy of the CLIA certificates must be attached to this form for verification purposes.

Contact Name

The contact person is the person who answers questions about the information provided on this form.

13. Contact name	14. Telephone
15. Contact email	

Authorized Signature Information

The undersigned, being the provider or having the specific authority to bind the provider to the terms of the provider agreement, does hereby agree to abide by and comply with all the stipulations, conditions, and terms set forth therein. The undersigned acknowledges that the commission of any Medicaid or CHIP-related offense, as set out in *42 USC 1320a-7b*, may be punishable by a fine of up to $25,000 or imprisonment of up to five years or both.

The owner, authorized official, or delegated administrator of the business entity directly or ultimately responsible for operating the business enterprise must complete this section. The *IHCP Delegated Administrator Addendum/Maintenance Form* must be completed before a delegated administrator can sign this form. The delegated administrator can sign only for items expressly delegated. The IHCP can process provider maintenance requests only when the appropriate signature is present. **The form will be returned if the appropriate signatures are not submitted.**

16. Legal name of provider's business (please print)	17. Taxpayer Identification Number (TIN)
18. Authorized official's name (please print)	19. Title
20. Authorized official's signature	21. Date